Those rates described as "fixed fee per unit value" in a relative value scale function as payment maximums and are derived from an annual study of usual and customary charges. Providers are continually asked to bill their customary fees.

The "median methodology" involves the application of a precise mathematical computation. First, the State categorizes all pertinent charges to Nevada Medicaid from the previous calendar year specified by procedure, area of medicine (e.g., medicine, radiology, surgery) and provider type (e.g., physicians, podiatrists, dentists). Then the total billed charges for each procedure so specified are divided by the total corresponding number of RVS units (1974 CRVS or NRVS, as appropriate). The result is an average charge per RVS unit for each procedure within each area of medicine for each provider type. Each average is rounded to the nearest $.10 and then identical rounded averages are consolidated, with care taken to note the total number of charges that went into the calculation of each consolidated, rounded average. The rounded averages are then listed in ascending order and weighted by the total frequency of charges involved. The 50th percentile of weighted, rounded average charges per unit is selected as the median rate per unit to be used in setting a rate per unit for a given area of medicine and provider type. An interpolation between $.10 increments is performed if the median charge does not fall exactly on a $.10 increment. The interpolation is based on the proportionate frequency of occurrences of the two $.10 increments involved.

Each median rate thus derived is then compared to two others: the existing rate adjusted by the increase in the non-medical CPI for the calendar year in question, and the existing rate adjusted by the same percentage increase granted by the Legislature for all medical payments for the fiscal year in which new rates would apply. Barring large discrepancies, the lowest of the three may be adopted. Finally, the rates set will be affected by broad considerations of equity of rates for the same area of medicine among various provider types.

Methods and Standards Used to Determine Payment for Emergency Medical Services for Illegal Aliens

Hospital, emergency clinics, and county social service/welfare departments have been informed about the availability of emergency medical services and application procedures for aliens who have not been lawfully admitted for permanent residence or otherwise are not permanently residing in the United States under color of law.

When a hospital, clinic, or county social service department determines a person receiving emergency services is indigent and an illegal alien, the alien will be referred to the State Welfare Division District Office for application. If the applicant is unable or reluctant to go to the Welfare District Office, the hospital/clinic/social service department will assist the applicant in completing the application and gathering verification and will send the application and verification to the Welfare District Office with the billing(s).

The District Office eligibility worker will request from the provider a bill or other evidence services were rendered and will obtain an application (if not already completed) and necessary verifications/information. The eligibility worker will approve eligibility for the months in which services were rendered and the applicant meets income/resource and other criteria (e.g., disability or incapacity). (A Medicaid card will not be issued to the client.) Providers will be notified of client eligibility so applicable bills may be submitted to the Medicaid fiscal agent for payment determination and processing based on whether the alleged qualifying services actually met the emergency criteria. The fiscal agent will notify providers of the reason for any payment denial.

Medicaid will make payment only for the alien's care and services which are necessary for the treatment after sudden onset of an emergency medical condition. As defined in Section 1903(v), an "emergency medical condition means a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in --

"(A) placing the patient's health in serious jeopardy,

"(B) serious impairment to bodily functions, or

"(C) serious dysfunction of any bodily organ or part."

Payment for Qualified Medicare Beneficiaries (QMBs)

For Qualified Medicare Beneficiaries, Nevada Medicare will pay the Medicare deductibles and coinsurance subject to the following limitation: the Medicare payment (allowable charge) plus the deductible and coinsurance may not exceed the Medicaid maximum allowable payment. For Medicare services, which are not covered by Nevada Medicaid, or for which Nevada Medicaid does not have an established payment rate, Nevada Medicaid will pay the Medicare deductible and coinsurance amounts.

QMB claims for services which are covered by Medicare are not subject to Medicaid limitations. Medicaid will reimburse the deductible and coinsurance up to the Medicaid maximum allowable payment. Also prior authorization is not required for Medicare allowable services for dually entitled QMBs. If Medicare benefits are exhausted or Medicare does not cover the service and the service is covered by Medicaid, prior authorization is required if the service or benefit normally requires it.

REIMBURSEMENT FOR INDIAN HEALTH SERVICE AND TRIBAL 638 HEALTH FACILITIES

Effective January 1, 2000 Nevada Medicaid will reimburse Indian Health Services facilities and Tribal 638 facilities in accordance with the most recent published Federal Register notice.

The published rate is paid for each face-to-face encounter/visit. Each encounter/visit may include any one or more services and medical professionals listed below:

Physician/Osteopath
Podiatrist
Dentist
Certified Registered Nurse Practitioner
Nurse Anesthetist
Nurse Mid-Wife
Physician Assistant
Optometrist
Psychologist
Radiology
Pharmacy – including drugs dispensed
Opticians – including eyeglasses and/or contact lenses dispensed
Clinical Laboratory

MAXIMUM MEDICAID PAYMENT RATES FOR
LISTED OBSTETRICAL AND PEDIATRIC PRACTITIONER SERVICES
STATEWIDE APRIL 1, 1997

Procedure Code	Procedure Description	04/01/96 Maximum Payment	04/01/97 Maximum Payment
Maternity Care and Delivery			
Incision			
59000	Amniocentesis, any method	$ 76.84	$ 78.76
59012	Cordocentesis (intrauterine), any method	$ 76.84	$ 78.76
59015	Chorionic villus sampling, any method	$ 332.98	$ 341.30
59020	Fetal contraction stress test	$ 76.84	$ 78.76
59025	Fetal non-stress test	$ 26.89	$ 27.56
59030	Fetal scalp blood sampling	$ 76.84	$ 78.76
59050	Initiation and/or supervision of internal fetal monitoring during labor by consultant with written report (separate procedure)	$ 83.25	$ 85.32
59051	Interpretation only	$ 66.59	$ 68.26
59100	Hysterotomy, abdominal (eg, for hydatidiform mole, abortion)	$1062.98	$1089.54
Excision			
59120	Surgical treatment of ectopic pregnancy; tubal or ovarian, requiring salpingectomy and/ or oophorectomy, abdominal or vaginal approach	$1062.98	$1089.54
59121	Tubal or ovarian, without salpingectomy and/or oophorectomy	$1024.56	$1050.16
59130	Abdominal pregnancy	$ 865.75	$ 887.38

Procedure Code	Procedure Description	04/01/96 Maximum Payment	04/01/97 Maximum Payment
59135	Interstitial, uterine pregnancy requiring total hysterectomy	$1280.70	$1312.70
59136	Interstitial, uterine pregnancy with partial resection of uterus	$1280.70	$1312.70
59140	Cervical, with evacuation	$ 865.75	$ 887.38
59150	Laparoscopic treatment of ectopic pregnancy; without salpingectomy and/or oophorectomy	$ 614.74	$ 630.09
59151	With salpingectomy and/or oophorectomy	$ 640.35	$ 656.35
59160	Curettage, postpartum (separate procedure)	$ 320.17	$ 328.17
Introduction			
59200	Insertion of cervical dilator	$ 199.78	$ 204.78
Repair			
59300	Episiotomy or vaginal repair, by other than attending physician	$ 153.68	$ 157.52
59320	Cerclage or cervix, during pregnancy; vaginal	$ 320.17	$ 328.17
59325	Abdominal	$ 896.49	$ 918.89
59350	Hysterorrhaphy of ruptured uterus	$1062.98	$1089.54
Delivery, Antepartum and Postpartum Care			
59400	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy and/or forceps) and postpartum care	$1212.82	$1243.12

Procedure Code	Procedure Description	04/01/96 Maximum Payment	04/01/97 Maximum Payment
59409	Vaginal delivery only (with or without episiotomy and/or forceps)	$ 873.43	$895.26
59410	Including postpartum care	$1039.92	$1065.91
59412	External cephalic version, with or without tocolysis	$ 313.77	$ 321.61
59414	Delivery of placenta (separate procedure)	$ 345.78	$ 354.42
59420	Antepartum care only: Prorate/10 visits *Retain old CPT code	$ 303.52	$ 311.10
59425	Antepartum care only; 4-6 visits, see 59420	NMB	NMB
59426	*7 or more visits (Prorate to 1), see 59420	NMB	NMB
59430	Postpartum care only (separate procedure)	$179.29	$ 183.77
Cesarean Delivery			
59510	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care	$1544.52	$1583.62
59514	Cesarean delivery	$1206.41	$1236.56
59515	Cesarean delivery only including postpartum care	$1456.15	$1492.53
59525	Subtotal or total hysterectomy after cesarean delivery	$ 397.01	$ 406.93
Abortion			
59812	Treatment of spontaneous abortion, any trimester, completed surgically	$ 345.78	$ 354.42
59820	Treatment of missed abortion, completed surgically; first trimester	$ 373.96	$ 383.30
59821	Second trimester	$ 409.82	$ 420.06

Procedure Code	Procedure Description	04/01/96 Maximum Payment	04/01/97 Maximum Payment
59830	Treatment of septic abortion, completed surgically	$ 409.82	$ 420.06
59840	Induced abortion, by dilation and curettage	$ 373.96	$ 383.30
59841	Induced abortion, by dilation and evacuation	$ 373.96	$ 383.30
59850	Induced abortion, by one or more intra-amniotic injections	$ 590.40	$ 605.15
59851	With dilation and curettage and/or evacuation	$ 742.80	$ 761.36
59852	With hysterotomy (failed intra-amniotic injection)	$ 998.94	$1023.90
59855	Induced abortion, by one or more vaginal suppositories (e.g., prostaglandin) with or without cervical dilation (e.g., laminaria);	$ 699.26	$ 716.73
59856	With dilation and curettage and/or evacuation	$ 856.78	$ 878.19
59857	With hysterotomy (failed medical ovaluation)	$1106.52	$1134.17
Other Procedures			
59870	Uterine evacuation and curettage for hydatidiform mole	$ 473.86	$ 485.69
59899	Unlisted procedure, maternity care and delivery	By Report	By Report
Pediatric Practitioner Services			
Evaluation and Management			
Office or Other Outpatient Services			
New Patient			
99201	Physicians typically spend 10 minutes	$ 29.44	$ 30.14

Procedure Code	Procedure Description	04/01/96 Maximum Payment	04/01/97 Maximum Payment
99202	Physicians typically spend 20 minutes	$ 37.92	$ 38.83
99203	Physicians typically spend 30 minutes	$ 52.39	$ 53.65
99204	Physicians typically spend 45 minutes	$ 79.19	$ 81.09
99205	Physicians typically spend 60 minutes	$ 98.40	$ 100.76
Established Patient			
99211	Typically 5 minutes are spent supervising or performing these services	$ 17.46	$ 17.88
99212	Physicians typically spend 10 minutes	$ 28.44	$ 29.12
99213	Physicians typically spend 15 minutes	$ 32.43	$ 33.21
99214	Physicians typically spend 25 minutes	$ 46.45	$ 47.57
99215	Physicians typically spend 40 minutes	$ 77.64	$ 79.51
Office or Other Outpatient Consultations New or Established Patient			
99241	Physicians typically spend 15 minutes	$ 39.47	$ 40.42
99242	Physicians typically spend 30 minutes	$ 61.77	$ 63.26
99243	Physicians typically spend 40 minutes	$ 79.84	$ 81.76
99244	Physicians typically spend 60 minutes	$ 111.87	$ 114.56
99245	Physicians typically spend 80 minutes	$ 148.60	$ 152.17

Procedure Code	Procedure Description	04/01/96 Maximum Payment	04/01/97 Maximum Payment
Confirmatory Consultations			
New or Established Patient			
99271	Usually the presenting problem(s) are self limited or minor	$ 37.92	$ 38.83
99272	Usually the presenting problem(s) are low severity	$ 52.39	$ 53.65
99273	Usually the presenting problem(s) are moderate severity	$ 70.95	$ 72.66
99274	Usually the presenting problem(s) are moderate to high severity	$ 87.32	$ 89.42
99275	Usually the presenting problem(s) are moderate to high severity	$ 125.94	$ 128.97
Home Services			
New Patient			
99341	Usually the presenting problem(s) are low severity	$ 47.90	$ 49.05
99342	Usually the presenting problem(s) are moderate severity	$ 57.23	$ 58.61
99343	Usually the presenting problem(s) are high severity	$ 74.85	$ 76.65
Established Patient			
99351	Usually the patient is stable, recovering or improving	$ 32.44	$ 33.21
99352	Usually the patient is responding inadequately to therapy or has developed a minor complication	$ 49.25	$ 50.43
99353	Usually the patient is unstable, or has developed a significant complication or a significant new problem	$ 59.73	$ 61.16